Abstract

Extensive histories of complex developmental trauma and insecure attachment are widespread among people given a diagnosis of personality disorder in forensic settings, and are likely to be important predisposing factors that contribute to their offending behavior. In working with this population, it is important to bear this in mind, and helpful to formulate clients' challenging behaviors as a set of learned responses to perceived threat, or as survival strategies. Such an approach not only makes the interviewing process more effective, it also helps to avoid perpetuating destructive patterns of behavior and relationship between forensic clients and people in authority. We present seven principles for effective interviewing with this population; a) careful preparation; b) a constant focus on the therapeutic relationship; c) providing structure and containment; d) adopting a flexible approach; e) managing therapy-interfering behaviors; f) obtaining supervision; and g) adopting a whole-team approach.

Introduction

The label of personality disorder is a controversial one. It can be stigmatising, can mask the problems it is supposed to help address, and can add to the problems that people with the label experience (Bodner et al., 2015; Lam et al., 2016). Nevertheless, where access to mental health services is contingent on a psychiatric diagnosis, a label of personality disorder can be the only way that some people can access help. This may be particularly true in forensic services. It is beyond the scope of this paper to discuss the merits of the label. The consensus statement for people with complex mental health difficulties who are diagnosed with a personality disorder (Lamb, Sibald & Stirzaker, 2018) uses the term "people given a diagnosis of personality disorder". We use the term throughout this paper as it is neutral as to the value or legitimacy of the label, while reflecting the fact that a diagnosis has been made, and that it is "given" by others, but not necessarily accepted by the person.

There is a strong association between a history of abuse or neglect in childhood and a diagnosis of personality disorder in adulthood. A number of retrospective studies have reported high rates of abuse and neglect among individuals given a diagnosis of personality disorder (Afifi, et al., 2011; Johnson, Liu & Cohen, 2011), with particularly high rates among individuals given a diagnosis of borderline personality disorder (Pietrek et al., 2013). In a prospective study, Widom, Czaja, and Paris (2009) reported that children with documented histories of physical and sexual abuse and neglect were specifically at increased risk of having a diagnosis of borderline personality disorder in adulthood, compared to demographically matched controls. Another prospective study by Shi et al. (2012) found an association between childhood maltreatment, maternal withdrawal in infancy, disorganized attachment behavior, maladaptive behavior at school and later antisocial personality disorder features.

A recent audit of trauma histories, based on case records and self-report to therapists and social workers, in the high secure personality disorder service where the lead author works, revealed that all 77 patients for whom data were available reported or were reported to had experienced significant developmental trauma. Of these, 64 out of 77 patients (83.11%) had reported a history of physical abuse in childhood; 53 patients (68.83%) reported a history of childhood sexual abuse; 66 (85.71%) reported a history of childhood emotional abuse; 65 (84.42%) reported a history of childhood emotional neglect; and 28 (37.66%) reported a history of childhood physical neglect. In addition, 29 (37.66%) reported the death of a significant adult during childhood and 39 (50.65%) reported having been in care. Six patients (7.79%) reported experiencing a single category of abuse or neglect; 8 (10.39%) reported two categories; 19 (24.68%) reported three categories; 19 (24.68%) reported four categories and 25 (32.47%) reported abuse or neglect in all five categories. Since these figures are largely based on self-report, it was not possible to validate them. Nevertheless, they do suggest that significant developmental trauma is the norm for this population.

Another common feature of this population is a pattern of frequent conflict with, and disengagement from, services. Cluster B personality disorder traits are associated with various indicators of interpersonal dysfunction, including distress and conflicts in relationships, few close friends, and limited social support; they are also associated with increased rates of workplace conflict and disciplinary problems leading to dismissal or demotion (Hengartner, Müller, Rodgers, Rössler, & Ajdacic-Gross, 2014a, b). A history of conduct disorder and delinquent behavior is associated with increased risk of dropping out of therapy in children (Lyon & Budd, 2010), while antisocial personality traits are associated with increased risk of dropout for adult males in correctional programs (Olver, Stockdale, & Wormith, 2011). While interpersonal dysfunction may be common among people given a diagnosis of personality disorder, the anti-authority attitudes of forensic clients often make relationships with people in authority particularly problematic. A history of treatment failure, drop-out and exclusion in the education, social care, criminal justice and mental health systems may often perpetuate and reinforce dysfunctional behavior patterns and underlying core beliefs about self, others and the world (Jones, 2007).

Insecure patterns of attachment are common among people given a diagnosis of personality disorder (Bakermans-Kranenburg & van IJzendoorn, 2009; Levy et al., 2005). There is growing evidence that insecure childhood attachment and complex trauma affect the child's neurological development (Schore, 2015), and is associated with subsequent problems with emotion regulation (Mikulincer & Shaver, 2018), hypervigilance to threat (De Bellis & Zisk, 2014) impaired mentalization ability and identity development (Fonagy, Gergely, Jurist, & Target, 2018).

The Power Threat Meaning Framework

As an alternative to traditional medical diagnostic categories, the Power Threat Meaning Framework (British Psychological Society, 2018) has been developed to enable "the

construction of non-diagnostic, non-blaming, de-mystifying stories about strength and survival, which re-integrate many behaviours and reactions currently diagnosed as symptoms of mental disorder back into the range of universal human experience" (pp.17-18). Although the framework has yet to be tested empirically as a valid and reliable means of describing and explaining complex mental health problems, it has an extensive evidence base. The framework consists of four inter-related aspects:

a) the operation of interpersonal, social, cultural, legal and economic power;
b) the threat that the negative operation of power poses to individuals, groups and communities, causing emotional distress;
c) the central role of the meaning of that threat to the individual, group or community in shaping the experience of power and threat, and the individual's response;
d) the learned and evolved threat responses that a person, group or community draws upon to ensure their emotional, physical, relational and social survival.

The Power Threat Meaning Framework suggests several provisional general patterns of meaning-based threat responses to power. It should be stressed that these general patterns do not represent discrete clusters or universal explanations for specific 'symptoms', nor should they be seen as replacements for diagnostic terms. However, they represent patterns in the meaning of threat and the function of the threat response. One such pattern is described as "surviving social exclusion, shame and coercive power". The Power Threat Meaning Framework proposes that individuals showing this pattern are more likely to be given a diagnosis of antisocial personality disorder and to engage in criminal activity. People meeting the criteria for a diagnosis of personality disorder, and particularly those with antisocial features, are over-represented in forensic settings (Fazel & Danesh, 2002). These individuals have often experienced significant adversities both in childhood and adulthood, including physical and sexual abuse, witnessing domestic violence, harsh or humiliating parenting styles,

and insecure attachments (Hoeve et al, 2008; Holt, Buckley & Whelan, 2008; Ogilvie, Newman, Todd & Peck, 2014; Widom, 2017). They are also more likely to have grown up experiencing threat, discrimination, material deprivation and social exclusion (Alm & Estrada, 2017; Farrington, 2003), including institutional care (Darker, Ward & Caulfield, 2008) and homelessness (Cronley, Jeong, Davis & Madden, 2015). The Power Threat Meaning Framework suggests that such individuals tend to use survival strategies of cutting off from their own and others' emotions, being highly alert to threat, and having a hostile and aggressive interpersonal style.

Suspicious thinking or 'paranoia' is commonly associated with this pattern, although it is also found with other patterns. Suspicious thinking has also been shown to have roots in insecure attachments, witnessing domestic violence, poverty, institutional care and experiences of bullying, assault and other physical threats (Bentall, Wickham, Shevlin & Varese, 2012; Ellett, Freeman & Garety, 2008; Kline et al., 2016; Wickham, Sitko & Bentall, 2015).

Violence and aggression have many similar developmental antecedents as 'paranoia', and the two are sometimes linked in this pattern, in that violent or aggressive threat responses may be easily triggered in response to perceived danger, especially since the development of reflective abilities may have been impaired in early life (Taubner, Zimmermann, Ramberg & Schröder, 2016). Thus, many, though not all, violent and offending behavior can be understood as survival responses.

Using the Power Threat Meaning Framework, we propose that, for clinicians working with such individuals in forensic settings, "*personality disorder" is best understood as a set of learned responses to perceived threat, or as survival strategies for keeping physically and psychologically safe in interpersonal environments that are seen by the individual as dangerous, hostile, abusive or neglectful*. Common survival strategies in forensic settings include, emotional detachment, hypervigilance to threat, hostility and aggression. These

strategies may often be effective in the short term at achieving psychological safety in the face of perceived threat. However, in the longer term, they can have a toxic and corrosive impact on effective social functioning and stable interpersonal relationships, particularly when professional respond to them in a controlling or punitive manner.

We have found this definition to be easily understood by both clients and staff. It provides a non-stigmatizing framework with which to make sense of the diagnosis of personality disorder and its behavioral, cognitive, emotional, interpersonal and identity-related manifestations.

Gender Issues

In general, custodial environments are likely to be traumatizing and triggering for both men and women, although the nature of their past trauma and their behavioral responses may be very different. Men in the criminal justice system are more likely to have experienced physical assault or witnessed violence, while women are more likely to have experienced sexual abuse or intimate partner violence (Carlson & Shafer, 2010; Moloney, van den Bergh & Moller, 2009).

There is evidence that boys and girls respond differently to childhood abuse. Waxman et al. (2014) reported that men who had been maltreated in childhood were more likely to meet criteria for diagnoses of antisocial, narcissistic or schizotypal personality disorders, while women were more likely to meet criteria for diagnoses of avoidant, borderline, dependent or paranoid personality disorders, suggesting that, in general, boys are more likely to respond to maltreatment by acting out, while girls are more likely to respond with social withdrawal.

The trauma histories of individual clients are likely to influence how they perceive and interact with male or female mental health professionals. The overwhelming majority of child sexual abuse is perpetrated by males rather than females, though rates of physical abuse against children by males and females are more similar. (Australian Bureau of Statistics, 2005; May-

Chahal & Cawson, 2005; McCloskey & Raphael, 2005; Peter, 2009). However, when taking issues of severity into consideration, males have been found to be responsible for more severe physical abuse than female perpetrators (US Department of Health and Human Services, 2005). Child protection data indicates that women are more likely than men to be responsible for child neglect (US Department of Health and Human Services, 2005). From the limited available research, emotional child abuse is perpetrated by both males and females (Sedlak et al., 2010).

Culture and Identity

While a poorly developed and integrated sense of self is generally associated with people given a diagnosis of borderline personality disorder, there is also evidence that identity problems are widespread among people given a diagnosis of personality disorder (Lynum, Wilberg & Karterud, 2008; Westen, Betan & Fife, 2011). A sense of alienation and rejection also appears widespread among forensic personality disorder populations, perhaps not surprisingly, given their frequent histories of abuse and conflict with authority. Arguably the combination of a limited sense of identity and strong sense of alienation leads members of this group sometimes to identify strongly with other marginalized or alienated groups based, for example, on the basis of religious affiliation or sexual orientation. In the experience of the authors, forensic patients given a diagnosis of personality disorder seem more likely to identify themselves on the basis of minority national or regional identity, or on the basis of aspects of identity that might be seen as relatively unimportant in the general population, such as musical preferences or sporting allegiances. As with gender, it is important for interviewers to be mindful of client's sense of identity, and how it may affect their presentation in interview.

Approaches to Interviewing

If personality disorder is best understood as a set of effective yet dysfunctional survival strategies for interpersonal situations, then interviewing people given the diagnosis is perhaps

best understood as a process of identifying and helping the client to identify those patterns and their functions. Interviewing a client given a diagnosis of personality disorder then becomes a microsystem within a wider clinical framework, where similar approaches to addressing maladaptive behavior might be beneficial in maximizing the client's engagement and participation.

A review of the literature on the treatment of people given a diagnosis of personality disorder reveals a number of similarities in the overarching strategies recommended to work with this client group:

- Knowing your client and planning for potential interpersonal problems
- Building a trusting relationship
- Providing structure and containment
- Adopting a flexible approach
- Managing therapy-interfering behaviors and relationship ruptures
- Obtaining supervision to know and manage yourself
- Adopting a 'whole team' approach

We have used these seven overarching strategies as a framework to discuss best practice in the interviewing of clients given a diagnosis of personality disorder.

a) Knowing Your Client and Planning for Potential Interpersonal Problems

Perhaps the most obvious difficulty in interviewing this client group is the wide range of challenging or therapy-interfering behaviors with which they can present, both within and outside the session. Traditional personality disorder diagnostic categories are of little use in formulating or managing such behaviors (Logan & Johnstone, 2010; Macneil, Hasty, Conus & Berk, 2012). Instead, it is helpful to use a formulation model linked to one of the treatment frameworks specifically tailored to personality disorder to explore the client's likely presentation in an interpersonal setting such as an interview. Using a cognitive-analytic

framework, this might mean reviewing the client's repertoire of procedural sequences and exploring any indicated traps, dilemmas and snags that interfere with them (Ryle,1997); using a dialectical behavior therapy framework, it might involve reviewing the client's behavioral patterns in terms of dialectical dilemmas posed (Linehan, 1993); or, using a cognitive-behavioral framework, it could involve determining their likely core beliefs, expectations and rules for living (Beck, Davis & Freeman, 2016). In our conceptualization of personality disorder, these behaviors can be understood as survival behaviors, whose function is keep the client physically and psychologically safe. Schema mode theory (Young, Klosko & Weishaar, 2003) describes these survival behaviors as coping modes and divides them into three categories; avoidant, over-compensatory and surrender.

Examples of avoidant coping behaviors include:

- Minimizing or denying any problems, presenting in an overly positive manner;
- Intellectualizing or changing the subject to avoid discussing difficult or distressing matters;
- Guarded, minimalistic presentation, with superficial disclosure;
- Angry presentation that leaves the clinician with the sense that the client is not angry at them but is using anger as a barrier.

Examples of over-compensatory coping behaviors include:

- Dismissive; belittling or attacking the clinician;
- Self-aggrandizing; presenting as demanding and controlling the interview;
- Paranoid/ hostile, questioning the clinician and his/ her motives.

Examples of surrender coping behaviors include:

- Overly compliant or suggestible, telling the interviewer "what they want to hear";
- Distressed, vulnerable; presenting in constant crisis.

People given a diagnosis of personality disorder rarely have a single mode of presentation. More often they will switch between several of these, sometimes in quick succession. This can happen within a single session with one individual, but it is also manifested when clients present different coping modes with different members of the same team. This latter phenomenon is often referred to as "splitting", which we discuss later.

The over-compensatory presentations are the most obvious to spot, and probably the most anxiety-provoking for clinicians. However, other presentations are just as therapy-interfering, and easier to miss, or to inadvertently collude with and reinforce. Formulating in this way can help to alert the interviewer to the client's likely maladaptive responses to being interviewed. Once identified, many of these can be offset or minimized by flexible planning, careful presentation of the process and contracting that is sensitive to the client's needs.

b) Building a Trusting Relationship

Arguably, all therapeutic approaches developed specifically for people given a diagnosis of personality disorder stress the importance of the therapeutic relationship (e.g. mentalization-based treatment, Fonagy & Bateman, 2006; schema therapy, Kellogg & Young, 2006; transference-focused psychotherapy, Levy et al., 2006; dialectical behavior therapy, Linehan, 1993; cognitive analytic therapy, Ryle, 1997). With forensic clients given a diagnosis of personality disorder this can often be the key issue in the success of the intervention, and it poses particular problems (Livesley, 2003). Most clients will have been through an interview process many times before, and may have experienced this as unhelpful, or worse, as abusive. For example, clients given a diagnosis of personality disorder interviewed by Willmot (2011) reported experiencing overt abuse, angry or punitive responses and suspiciousness by interviewers as a result of their diagnosis or their own challenging behavior in interview. On the basis of their past experiences, clients may approach interviews with the expectation of being rejected, abused or misled, and may respond in a hostile or defensive manner in

anticipation of such treatment. By anticipating such negative responses, the interviewer can guard against responding punitively to the client's hostility or avoidance. We have found it helpful to pre-empt such responses by starting the interview process with a discussion of the client's previous experiences of interviewing, and asking what they found helpful and unhelpful in previous interviews. Open and empathic communication about the client's past experiences and concerns, and an acceptance of the client and of the client's agenda are important first steps in building a trusting relationship.

Empathy, congruence and positive regard. As with any therapeutic relationship, the key facilitative conditions of empathy, congruence and positive regard identified by Rogers (1957) are essential in working with forensic clients given a diagnosis of personality disorder. Indeed, given the previous histories of abusive and failed relationships that are widespread among this client group, these conditions are arguably even more important. Unfortunately however, these conditions may also be more difficult for the therapist to generate with clients who are difficult to work with, who can provoke strong emotional responses and relationship ruptures, and who may have committed serious and appalling offences. While this is a problem that all forensic mental health practitioners must manage, surprisingly little has been written or research on how they manage it. We suggest the following assumptions may be helpful to foster these facilitative conditions, adapted from Linehan (1993):

- This person is a survivor. They do what they do because it has helped them to survive.
- At some level, they are unhappy with the way they are, and they want to change, otherwise they would not be here.
- They are doing the best they can.

Above all, it is important that the clinician does not take hostile, abusive or withdrawn behavior personally, but sees it for what it is; a well-learned and effective survival strategy.

Radical genuineness. Linehan (1993) quotes Rogers and Truax (1967) in her description of radical genuineness: "*He [sic] is without front or façade, openly being the feelings and attitudes which at the moment are flowing in him. It involves the element of self-awareness, meaning that the feelings the therapist is experiencing are available to him, available to his awareness, and also that he is able to live these feelings, to be them in the relationship, and able to communicate them if appropriate. It means that he comes into a direct personal encounter with his client, meeting him on a person-to-person basis. It means he is being himself, not denying himself*" (p.101). Clients who experienced neglect or abuse by carers tend to be hypervigilant to the nuances of attitude and emotion in others, particularly those in caring roles. Clients are unlikely to relate to an interviewer who feigns views they do not hold or who offers only the professional aspect of themselves. This does not imply the need for boundary breeching, but it does require the interviewer to be "real" or "radically genuine".

Managing expectations of stigma. Outside forensic settings, personality disorder is still a stigmatizing label (Bilderbeck, Saunders, Price & Goodwin, 2014; Lawn & McMahon, 2015). In our experience, within forensic settings, which tend to be awash with stigmatizing labels, personality disorder may be one of the more benign, and may be positively attractive to clients who prefer to identify with alienated subgroups. We generally introduce the assessment process with the conceptualization of personality disorder described in the introduction, and use this as a basis to start exploring some of the client's thoughts, feelings and behaviors. It can be helpful start with a discussion of the protective function and benefits of coping behaviors before exploring the costs of these behaviors.

Ending well. With their frequent experiences of abuse, rejection and conflict, many clients in this population come to expect that relationships will generally end suddenly and badly. It is therefore important that they experience healthy relationship endings in their therapeutic relationships. Even in time-limited assessments, ending should be discussed well

before the final session; the normal processes of loss and grief should be explained, and the therapist should model expressing appreciation for what the client has brought to the relationship and sorrow about the ending of the relationship. This modelling should be calibrated to what the client is likely to be able to tolerate. Clinicians should be alert to the risk that the client's anxiety may well increase as the final session approaches, along with urges to avoid sessions or to sabotage the relationship in order to revert to their "normal" method of ending relationships. We generally mark the final session with an exchange of ending letters, in which each person expresses their appreciation of the other's contribution to the relationship and their hopes for the future. The ending letter also provides a useful opportunity for the clinician to remind the client of the insights they have developed, and of their motivational statements and goals (Ingrassia, 2003; Tsai et al., 2017).

Providing Structure and Containment

Many forensic clients given a diagnosis of personality disorder engage in behaviors that are dangerous to themselves and others, or fail to react adaptively to dangerous situations. As a result, many of the therapeutic frameworks for working with this population emphasize the need to for therapeutic structure and emotional containment to keep clients safe (Linehan, 1993; Livesley & Clarkin, 2015). Interview processes, particularly those occurring outside of, or preceding a therapy intervention, also need to offer adequate structure and containment to maintain safety and manage risks.

Structure. Benjamin and Karpiak (2002) suggested that having a relatively active therapist, a clear structure, and setting limits on unacceptable client behavior are uniquely important in working with people given a diagnosis of personality disorder. There are a number of reasons why structure is so important with this client group. Most of the therapeutic models used to make sense of the client's presenting problems focus on an underpinning structure of maladaptive thoughts, feelings and behavioral patterns. Thus, the interview is likely to take a

directive approach, focusing on identifying these patterns. Without structure, there is a danger that the therapist will simply end up reacting to the client's shifting and dysfunctional coping behaviors. If this prevents the clinician from discussing difficult or distressing issues, then this risks negatively reinforcing those behaviors. For clients with a history of abuse, structure and predictability can reduce feelings of uncertainty and vulnerability. It can also enable the clinician to model a relationship in which the client is able to feel contained without feeling controlled or manipulated. Structure includes ensuring that sessions start and end punctually, that a clear but flexible agenda is agreed at the start of sessions, and that issues carried over from the previous session are dealt with. Where an important issue arises that deviates from the agreed plan, then a boundaried time at the beginning or end of the session should be agreed so that the issue does not dominate the whole session.

Emotional containment. People given a diagnosis of personality disorder frequently struggle to experience, identify, express and manage emotions in a healthy way. Clients are often described in the literature as being at the mercy of their emotional responses (Linehan, 1993; Young, Klosko & Weishaar, 2003) so that emotions are often suppressed, overwhelming, or "out of synch" with the stimulus event. The interview situation is often a critical event, the outcome of which can lead to life-changing results. It is also a situation in which difficult topics are likely to be explored, and difficult behaviors and attitudes may be exposed. Both interviewer and client need to be confident in the interviewer's ability to contain and manage client (and interviewer) emotions. At the most basic level, the physical safety of both client and interviewer need to be ensured, both during and after the interview. Addressing these concerns at the very start of the interview in an open and sensitive way will allow advance collaborative contingency planning and serve to reassure the client.

From time to time throughout the process it is helpful to solicit emotional reactions. This can serve to validate emotional responses by helping the client identify emotions and by

"giving permission" to feel them; and it will help to contain emotional responding by gauging the level of emotional reaction and by helping to "shape" emotional expression. Strong emotional responses that arise during an interview need to be dealt with immediately. Interviewers should not ignore, confront or bypass a significant emotional response. Such attempts are likely to re-enact negative or invalidating past experiences for the client and will probably elicit further very strong negative reactions. Strong emotional reactions are also often a rich source of information about the client if explored sensitively, and so should not be overlooked.

"Never allow a crisis to go to waste". Willmot (2011) found that crises were often therapeutic turning points for forensic clients given a diagnosis of personality disorder. Their previous experience of crises was often that, at the point when they most needed help and support, that support was withdrawn; relationships would end suddenly, services would discharge them or refer them elsewhere or they would be moved to a different unit. This tended to reinforce their sense of themselves as failing and incompetent, of others as rejecting and uncaring, and of relationships as fragile. In contrast, participants in Willmot's study described a turning point in their therapy as being the experience of consistent support by another person or by their whole team in a time of crisis, which had ended up strengthened their relationship with those people instead of damaging it, as they had initially feared. Crises are common in this client group, and the initial formulation should include likely triggers and responses. In our experience, clients given a diagnosis of personality disorder often seem to go through similar crises in different placements. Therefore, when a client is admitted to a new unit following the breakdown of a previous placement, it is important that the new team anticipate that similar problems may reoccur in the present setting, and have plans in place on how to manage them if they do. We would generally advise that, wherever possible, the client is informed about and involved in this planning. While this may trigger a suspicious initial response, for example that

"you are expecting me to assault one of you, so you don't trust me", the client may well expect staff to be mistrustful and be hypervigilant for signs of mistrust. Involving the client in relapse prevention planning allows for an open discussion of risk issues which, in the longer term, should promote trust and positive therapeutic relationships.

d) Adopting a Flexible Approach

Developing shared goals. Establishing and maintaining motivation and hope are essential if clients are to engage and stay engaged. However, low motivation and feelings of helplessness are common in this client group, with their histories of frequent conflict with authority and disengagement from services. Clinicians need to make extensive use of motivational interviewing techniques (Arkowitz, Miller & Rollnick, 2015) to maintain a commitment to change. Clinicians should keep a note of previous successes and changes, no matter how small and remind clients of these. At times when motivation is poor, clinicians should maintain a supportive stance and attempt to reinforce motivation by exploring the consequences of maladaptive behavior, rather than adopting a more confrontational and challenging approach which is likely to further damage the therapeutic relationship and increase reactivity.

The goals of forensic clients and what they perceive to be the interviewer's goals may at times be very different. Particularly if the client has previous negative experiences of services, professionals and authority, his/ her own primary goals may be about survival (e.g. "saying what I need to say to get out"; "hiding the most shameful aspects of myself"; "not talking about distressing subjects"), while their perceptions of the interviewer's primary goals may be colored by their previous negative experiences (e.g. "keeping me detained"; "messing with my head"; "making me feel vulnerable"). Clients may also be reluctant to give up behaviors that others see as dangerous and dysfunctional, such as self-harm or aggressive behavior, if those behaviors have survival value for them.

It is particularly important with this client group to begin a discussion about treatment goals by asking the client what he/she wants to change. Acknowledging that dysfunctional behaviors can have value to the client may enable the client to explore the costs of these behaviors and to consider how they could be modified. It is also helpful to explain that treatment for individuals given a diagnosis of personality disorder is generally long term and progresses through various phases (Livesley & Clarkin, 2015), starting with managing crises and maintaining safety, then containing emotional and behavioral instability, developing strategies for self-management of emotions and impulses before addressing core personality problems. Thus, the aspects of change that the client may find the most difficult to consider may not actually be addressed for some time.

Pace and process. For many clients, the interview process itself may cause overwhelming feelings of vulnerability. For clients who see themselves as despicable or defective, and other people as a hostile and abusive, the idea of just talking to someone else, let alone disclosing information about their innermost thoughts and feelings is horrifying. For some clients a standard-length interview session may be unmanageable; instead they may benefit from shorter, more frequent sessions, or from more creative approaches to interview session. This can range from "distraction" activity during the interview such as games of cards or "doodling", through to the creative use of in-session therapeutic aids or exercises such as "mind maps", diagrams, relaxation or mindfulness exercises. Clients may also prefer written or pictorial homework exercises to elicit information to bring to future sessions. Some clients may find "pre-interview" interventions helpful, particularly with respect to emotional management or distress tolerance. Formulation of the client's difficulties regarding the interview should identify these pre-therapy goals. A certain flexibility of approach with regard to pace and process should make interviews easier for both parties in the early sessions, whilst the therapeutic relationship develops, and the client develops confidence and skills to manage

the process. Although apparently time consuming, this may in fact be a shorter route to effective interviewing of clients who have more severe presentations.

e) Managing Therapy-Interfering Behaviors and Relationship Ruptures

Linehan (1993) coined the term "therapy-interfering behaviors" to describe any behaviors that hamper therapeutic progress. This concept can also be applied to behaviors that interfere with the process of interviewing. Linehan advocates addressing therapy-interfering behaviors directly whenever they occur, noting that the danger of attempting to tolerate such behavior is that they can lead to clinician burn-out and the unilateral termination of the process. Thus, toleration is seen as potentially harmful to all concerned in the longer term.

Dysfunctional patterns, or "ruptures", in the therapeutic relationship, represent a particular kind of therapy-interfering behavior. They are often uncomfortable for the interviewer and they have the potential to disrupt the interview process completely. Nevertheless, relationship ruptures are often reflective of the client's interpersonal (and /or emotional) deficits, and can be seen as opportunities to build insight into dysfunctional interpersonal patterns. Safran, Muran and Eubacks-Carter (2011) advise that ruptures should be dealt with immediately, recommending an empathic approach that allows the client to express negative views and explore the problem.

Addressing therapy-interfering behaviors. Recognizing that this might not be a straightforward task, Linehan (1993) offers a strategy for addressing therapy-interfering behaviors that can be applied to an interviewing process. The strategy takes the form of an active, collaborative problem-solving approach that views the behavior as a shared problem for resolution (this is what you are doing, and this is how it impedes our progress). The interviewer should specify the therapy-interfering behavior and discuss and resolve with the client any discrepancies in their respective perceptions of it.

Once the interviewer and client have identified a therapy-interfering behavior, the behavior is then formulated in detail, focusing on the antecedent events, the response itself and the consequences of the response. Where particular elements of the chain of events are uncertain, the interviewer should offer hypotheses for discussion. Linehan notes a number of possible functions which can lead to clients resisting engagement including wanting to move on and focus on here and now problems, feeling ashamed, fearing being overwhelmed by emotion, or of being negatively judged. However, she stresses the need for an idiographic approach to the analysis.

Once the determinants of the behavior have been identified the interviewer and the client must agree on a means of reducing the behavior. Depending on the function of the behavior and the degree of control the client has over it, this may focus on motivational issues, changing reinforcement contingencies or environmental management; or preliminary work to train skills, reduce inhibitory emotions, or alter beliefs and expectancies.

Ruptures and the focus on process. While relational interpretations are a focus of psychodynamic approaches, a focus on the clinician-client relationship in session is also a feature of other therapies designed for people given a diagnosis of personality disorder, including dialectical behavior therapy (Linehan, 1993), mentalization-based therapy (Fonagy & Bateman, 2006) and schema therapy (Kellogg & Young, 2006). Although this focus is described differently in each model, in every case dysfunctional patterns in therapeutic relationship are understood as paralleling dysfunctional processes from the client's childhood, and helping the client to understand those patterns and to change them is a central element of therapy. A process for doing this might, at the very least, include the following steps:

- Drawing attention to the problem in a descriptive, non-judgmental way (for example, by saying, *"I notice that your body language and your tone of voice*

changed suddenly when I asked that question"; *"you're talking over me now, which means that neither of us can listen to what the other is saying"*).

- Asking the client about their current thoughts and feelings.
- Balancing validation for the client's feelings and history with focusing on how they can be effective in the present, and matching the level of feedback to the client. Early in the relationship, the clinician may simply validate the client's current emotions and manage their own response (*"I'm sorry my question made you feel that way, would you prefer if we come back to that later?"*). Later on, the focus can be more on helping the client to be effective in the moment (*"I know this is really difficult for you, and it makes you feel like you're back in that care home, but remember that you're not that frightened six-year-old and nobody here wants to hurt you. What can you do that would help you right now?"*)

This process is not straightforward, however, since interviewing, like other interpersonal situations, is transactional in nature. Safran, Muran and Eubacks-Carter (2011) note that, in order to negotiate ruptures constructively, interviewers require a basic capacity for self-acceptance, a willingness to self-explore, and a capacity to engage in a genuine dialogue with the client. Supervision is recommended to assist self-exploration and support self-acceptance.

f) Obtaining Supervision to Know and Manage Yourself

Supervision and support for interviewers. Linehan (1993) points out that some therapy-interfering behaviors may originate from the clinician (or interviewer) rather than the client, and stresses that these behaviors also need to be addressed for an effective process. As with client-generated therapy-interfering behaviors, there may be a number of functions underpinning the problematic behaviors. As we have noted, interviewing forensic clients given a diagnosis of personality disorder will often involve gathering information about traumatic

events and offending histories. Discussion of these topics in detail (which is necessary for effective formulation) can be aversive for interviewers as well as for the clients themselves. Interviewers may resist detailed discussion or condone their clients' avoidance to prevent undue distress. They may also do so to avoid potential power struggles about the interview's focus, or to avoid negative emotional reactions from the client. Moreover, interviewers, perhaps especially experienced ones, may believe that any inability to tolerate problematic behavior from their clients represents a failure of competence on their part. They may believe that since resistant behavior is to be expected with members of this client group, a skilled interviewer "should" be able to manage this. Linehan recommends that clinician-generated interfering behavior is reviewed as part of a clinical supervision or consultation process using a similar collaborative problem solving strategy of identification, formulation and solution analysis.

Apart from this normative role, clinical supervision can also offer a restorative function (Inskipp & Proctor, 1993) for interviewers, particularly when faced with some of the more distressing and anxiety-provoking behaviors. Recognizing the emotional demands that this group of clients can make on professionals, Linehan (1993) recommends that clinicians review and observe their own personal limits (i.e. "which client behaviors he or she is able and willing to tolerate and which are unacceptable": Linehan, 1993) when working with challenging clients who may be unable to monitor or limit their demands on others. However, whilst the observation of personal limits is recommended to prevent frustration and burn out, it is also acknowledged that interviewers' personal limits may change over time and in the face of competing demands. Interviewers may not always be aware that their limits have changed, and may need "permission" to observe them. Additionally, interviewers may need to extend their limits when a situation demands it (e.g. facing a crisis). The process of understanding and

accepting personal limits, and observing them but allowing considered extensions is best done within a supervisory context.

g) Adopting a 'Whole Team' Approach'

If individual relationships often trigger feelings of threat and vulnerability in this client group, then groups tend to do so even more. The wider interpersonal environment can reinforce the impact of individual therapy sessions, but it can also easily undermine it.

Consistency of approach. Suspiciousness and hypervigilance to threat are common among this client group, so inconsistencies in approach between team members are likely to be noticed, and to trigger anxiety. Willmot and McMurran (2013) studied the perceptions of forensic inpatients given a diagnosis of personality disorder about what had facilitated therapeutic change for them. Participants described feeling treated differently by staff in a specialist personality disorder treatment unit compared to how they had been treated previously, and specifically mentioned persistence, availability of support and a commitment to treatment by the whole staff team as an important factor.

Managing "splitting". It is inevitable in teams that different team members with different roles and different personalities will trigger different responses in individuals given a diagnosis of personality disorder. Often forensic clients, with insecure attachment patterns and long histories of conflict with authority figures, will tend to dichotomize clinicians into "good" (i.e. caring, supportive) and "bad" (i.e. authoritarian, uncaring, abusive) and to treat then accordingly. It is important that clinicians recognize that such thinking and behavior is, first and foremost, a transference response. Levy and Scala (2012) defined transference as "a tendency in which representational aspects of important and formative relationships (such as with parents and siblings) can be both consciously experienced and/or unconsciously ascribed to other relationships" (p.392). While it is possible that clients sometimes act in a consciously manipulative way to engineer splits in the team, such a view risks triggering a punitive or

confrontational approach that risks making the situation worse. In our experience it is far more common for such dichotomizing patterns to be emotion-driven responses to transference reactions, and it is more helpful for teams to treat such behaviors in this way, and to take responsibility for managing their responses to such behavior, rather than blaming the client. In other words, *patients don't split teams, teams allow themselves to split*.

Teams should ensure that their behavior towards the client does not inadvertently reinforce the client's dichotomous thinking, for by ensuring that it is not always the "good" staff who give the client positive feedback, and not always the "bad staff" who carry out "custodial" roles such as room searches or security checks. Ideally, "good" and "bad" staff should engage jointly in activities with clients. Above all, team members should avoid criticizing their colleagues in front of clients, or appearing to agree with criticism of colleagues by not challenging it.

It should be made clear to clients that team decisions are made by the whole team, not by individuals. It can be tempting at times to "blame" senior staff for unpopular decisions, particularly if those staff are remote from the client and are unlikely to come into direct contact. However, such scapegoating can inadvertently reinforce negative beliefs about authority figures. Although it can be time-consuming and emotionally draining, clients are more likely to understand and accept difficult decisions if the staff with whom they have the strongest bond take responsibility for the decision and for explaining it.

Team formulation. Teams can minimize the risk of splitting by having a shared team formulation of the client, to which the whole team contributes, so that all aspects of the client's presentation can be formulated. It often seems to be the most junior and least qualified members of the team who not only spend the most time with clients, but also who often seem to bear the brunt of their negative transference. These staff can easily be overlooked by the more senior members of the team, but because of the amount of contact they have with clients, their

influence on the dynamics between the client and the team, both positive and negative, can be enormous. They can also be a valuable source of both of detailed information about clients, but also of wisdom in how to manage them.

Emotional support for team members. Most writers acknowledge that clients given a diagnosis of personality disorder can be hard to treat and that burn out is a risk amongst those who work with them. It is therefore important that teams support, contain, balance and encourage each other (Gunderson & Links, 2014; Linehan, 1993). This requires the team to accept that team members are usually doing their best; to attempt to synthesize differing views about the client; and to acknowledge the difficulties faced by the interviewer and the progress made in the interview process.

Conclusion

People given a diagnosis of personality disorder are over-represented in forensic settings. The patterns of behavior that lead to their admission to these services often continue once they are admitted, making this an extremely challenging group to interview effectively. The Power Threat Meaning Framework suggests that many individuals in this group will have grown up experiencing and witnessing abuse, threat, discrimination, material deprivation and social exclusion. As a consequence, many have learnt to survive, physically and emotionally, by cutting off from their own and others' emotions, being suspicious and hypervigilant to threat, and presenting as hostile and aggressive.

Clinical settings, including interviews, that recreate or parallel formative early negative experiences for this client group are likely to reinforce patterns of dysfunctional behavior. Formulating these early experiences and meaning-based threat responses using the Power Threat Meaning Framework can enable clinicians to create an environment that is safe, structured and accepting, which, in turn, can allow clients to behave in ways that are not

primarily responding to perceived threat, and allow them to develop effective relationships with staff members.

At present, all the general patterns of meaning, including the "surviving social exclusion, shame and coercive power" pattern described in the Power Threat Meaning Framework, are described as provisional. While the literature supports the hypothesis that many forensic clients given a diagnosis of personality disorder have often grown up experiencing abuse, disrupted attachments, material deprivation and social exclusion, it is not clear how widespread is the pattern of meaning and response to threat proposed by the framework, or whether there are further sub-groups among people showing this pattern. An important next step would be to test the validity of this proposed pattern and its prevalence among forensic clients given a diagnosis of personality disorder, by conducting a thematic analysis of case formulations.

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